

## HUMAN SERVICES BOARD

## INTRODUCTION

## FINDINGS OF FACT

3. On July 23, 2005, T.M.G, a psych technician, overheard an exchange between the petitioner and E.W., a

patient. According to T.M.G, E.W. wanted to put his warm clothing in the box room. Petitioner repeatedly told E.W. that he should call his mother and store the clothing at home until the fall. E.W. asked petitioner for her name. There was silence for several seconds and then petitioner asked E.W. what his name was several times. E.W. did not respond. Petitioner told E.W. that he probably did not know his name. E.W. then said his name. Petitioner told him she did not think he was sure of his name. At this point, E.W. started to leave the room and told petitioner he was going to talk to his doctor about the petitioner. The petitioner replied that was okay because the staff talk to the doctor every day about him.

4. T.M.G. characterized the petitioner's tone of voice as harsh and demeaning.

5. T.M.G. testified that E.W. did not appear agitated.

6. T.M.G. testified that he was bothered by the exchange he witnessed between the petitioner and E.W. On July 24, 2006, T.M.G. and another employee who witnessed the exchange spoke to their charge nurse. T.M.G. was not sure whether the incident should be written up and sought guidance. The charge nurse reported to her supervisor who indicated that the incident needed to be written up.

7. Wilcox looked at interview notes of E.W. as part of her review. These notes indicated that E.W. found petitioner rude but not abusive.

8. On October 21, 2005, S.D. was in the medication room when she overheard the petitioner talking on the telephone to R.H., a patient. S.D. did not see petitioner during this conversation. S.D. testified that she heard petitioner tell R.H. to hang up the phone several times, that if he did not hang up the phone petitioner was going to stomp on his feet, repeated that he should hang up and if did not, the petitioner was going to come out and sew his mouth shut.

9. S.D. characterized the petitioner's tone of voice as derogatory. S.D. stated she was shocked by petitioner's tone of voice and conversation. She reported the incident to her supervisor that day.

10. S.D. saw R.H. after the incident and that R.H. seemed calm when she checked R.H. into dinner.

11. Wilcox investigated both allegations of abuse. As part of her investigation, she interviewed petitioner and the staff who witnessed each incident. Wilcox found the accounts of the staff consistent. Wilcox explained that the investigation of allegations of abuse are triaged based on the level of severity with 1 being the most severe and 4 the

least severe. Wilcox characterized the July 23, 2005 incident as a level 3 meaning moderate severity in which the Department is assuming there is not a high level of risk of harm down the road. Wilcox explained that the assurances of Vermont State Hospital that petitioner was being monitored was a factor they considered. The October incident was considered more severe because the incident involved the same staff member even though monitoring was in place.

12. A Commissioner's review was held on February 14, 2006 and April 21, 2006 affirming the determination that petitioner abused two vulnerable adults.

13. Petitioner was questioned by the Department at the fair hearing and confirmed that she had received a plan on or about August 4, 2005 dealing with being careful when speaking to patients. The plan was not submitted as evidence so that the specifics of the plan are unknown.

ORDER

The Department's decision substantiating abuse is reversed.

REASONS

The Commissioner of the Department of Aging and Independent Living (DAIL) is required by statute to investigate allegations of abuse of vulnerable adults, and to keep those records that are substantiated in a registry under the name of the person who committed the abuse. 33 V.S.A. §§ 6906 and 6911(b). If a report has been substantiated, the person who has been found to have committed abuse may apply to the Human Services Board for relief that the report is not substantiated. 33 V.S.A. § 6906(d).

Abuse has been defined in the statute protecting vulnerable adults, as follows:

(1) "Abuse" means:

(A) Any treatment of a vulnerable adult which places life, health or welfare in jeopardy or which is likely to result in impairment of health;

(B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering to a vulnerable adult;

(C) Unnecessary or unlawful confinement or unnecessary or unlawful restraint of a vulnerable adult;

(D) Any sexual activity with a vulnerable adult by a caregiver who volunteers for or is paid by a caregiving facility or program. . .

(E) Intentionally subjecting a vulnerable adult to behavior which should reasonably be expected to result in intimidation, fear, humiliation, degradation,

agitation, disorientation, or other forms of serious emotional distress; or

(F) Administration, or threatened administration of a drug, substance or preparation to a vulnerable adult for a purpose other than legitimate and lawful medical or therapeutic treatment.

Credible evidence establishes that on two occasions, the petitioner engaged in a verbal exchange with a patient that can be characterized as inappropriate and unprofessional.

On July 23, 2005, petitioner repeatedly questioned a patient about his name, told the patient he did not know his name, and that staff discuss him with his doctors. The petitioner's tone of voice was characterized as harsh. There is no evidence that the patient was caused any unnecessary harm, pain, or suffering as contemplated by subsection (B) above. In addition, one can conclude that this conversation does not per se amount to intimidation or other forms of serious emotional harm as contemplated by subsection (E) above. By all accounts, the patient was not agitated by petitioner's behavior.

Several months later, petitioner told another patient as she attempted to get him off the telephone that she was going to stomp his feet and sew his mouth shut. Once again, no evidence was given that the second patient suffered any unnecessary harm, pain, or suffering as contemplated by

subsection (B) above. Nor was the evidence sufficient to show that the behavior was expected to result in emotional harm as contemplated by subsection (E) above. The patient was reported to be fine later that day.

The Department expressed concern that the petitioner had been warned about her conversational manner with patients; their concern appears to be what may happen to others rather than the particular impacts upon the two patients identified in the incidents.

The petitioner's behavior was neither appropriate nor professional. In fact, her behavior may not have been appropriate or professional with any hospitalized patient whether or not the patient was a vulnerable person. But, the Board has repeatedly held that inappropriate or unprofessional actions when dealing with a vulnerable adult do not automatically rise to the definition of "abuse" in the statute. See Fair Hearing Nos. 19,448; 18,698; 17,203; 16,822; and 15,325.

The Department has failed to meet its burden that the petitioner acted with the intent or recklessness to cause abuse pursuant to the definition of "abuse" in 33 V.S.A. §

6902. Accordingly, the Department's substantiation of abuse is reversed. 3 V.S.A. §3091(d), Fair Hearing Rule No. 17.

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